Welfare Pluralism in Health: Assessing Zimbabwe's Policy Response to Hiv/Aids With Reference to Mbare Distrct, Harare

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Abstract

The article is on Welfare Pluralism and focuses on Zimbabwe's policy responses to HIV/AIDS with reference to Mbare Disrict, Harare. Quantitative primary data was systematically collected from a sample of individuals from 159 households drawn from Ward 11 of Mbare. Qualitative primary data was collected from key informants who included health service providers, community leaders and individuals infected or affected by HIV/AIDS. Secondary data was collected through a documentary search. Findings from an impact assessment survey in Ward 11, based upon a rating scale of 1 to 5, revealed a highest average rating of 3 for the voluntary sector, followed by another good rating of 3 for government institutions and a fair rating of 2, 5 for the private sector. The informal sector received a lowest poor rating of 1, 6 which indicated gaps that are still to be exploited to maximise gains from joint interventions.

Key Words: Welfare Pluralism, HIV/AIDS, State, Civil-Society, Mbare

1.0 Background

The article is on Welfare Pluralism in health and provides a discussion on Zimbabwe's policy response to the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), with reference to Mbare District in Harare. It focuses interventions and contributions by the state and civil society towards this end. The article also assessed the impact of the interventions on the community. This follows a survey that was carried out in Ward 11 of Mbare, a high-density suburb in the southern parts of Harare, Zimbabwe. It is a densely populated area, with a long history of settlement by both locals and migrants, having been the first high-density suburb to be established in 1907. It is also characterized by socio-economic activity which typifies Harare. It is because of its status that it was purposively selected for this study. Ward 11 was however randomly selected on the basis that HIV/AIDS affects all members of the community in a manner that is similar and as such experiences were bound to be the same. Respondents were systematically selected using the alphabetical order criteria from households that were also systematically selected.

2.0 Welfare Pluralism

The concept of Welfare Pluralism, also known as the mixed economy of welfare has gained academic attention in health policy discourses in the modern era. Hatch et al. (1983) explains it as a policy prescription which assumes that social and health care must be delivered through four different sectors namely the statutory, voluntary, commercial and the informal. Implied in this is rolling back the frontiers of the state by maximizing voluntary and community based welfare provision as alternatives (Hadley et al., 1981; Mocroft et al., 1983). In this, the commercial sector is also believed to have a role to play in the provision of welfare even though it must be subject to safeguards with the aim of maintaining quality so that does not affect other sources of service provision detrimentally (Hadley et al., 1981). Welfare Pluralists question the assumption that the state should occupy a central role in the provision of welfare services (Mocroft et al., 1983). In pursuing a mixed economy of welfare, pluralists advocate expansion of the services provided by the voluntary, private and informal sectors. Most welfare pluralists accept the view that the state will continue to have a significant role, although not as a major service provider. The role prescribed for the state from this perspective is strategic and regulatory (Hadley et al., 1981; Mocroft et al., 1983).

This implies that the state should play a central role in the provision of welfare services, but should also, through its strategic role, promote the complementary role of the civil society in this endeavour.

3.0 Hiv/Aids Policy Framework in Zimbabwe

The response to HIV/AIDS in Zimbabwe was treated as a matter of emergency, since the discovery of the pandemic in 1985. There was an overwhelming response and commitment to Welfare Pluralism and Social Democracy in a bid to curb the pandemic's spread by reaching out to infected and affected members of society through state and civil society organizations (Baird, 2006; Bradshaw and North, 1997). Early policy interventions included the National AIDS Coordinating Programme (NACP).

3.1 The National Aids Coordinating Programme

The government of Zimbabwe adopted the World Health Organization (WHO) model of medium term plans in setting up this programme in 1987 (Baird, 2006; Government of Zimbabwe, 1999; Zimbabwe AIDS Network, 2009a). This resulted in the formulation of the One Year Emergency Short-Term Plan of 1987-88 whose main goal was on raising public awareness about the epidemiology surrounding HIV/AIDS. It was succeeded by the First Medium-Term Plan of 1988-93 and the Second Medium-Term Plan of 1994-98. These two were aimed at incorporating the civil society in raising public awareness, and implementation of interventions aimed at confronting the challenges associated with HIV/AIDS in the country. However, these early efforts were undermined by human, financial and material resource constraints due to austerity measures associated with the Economic Structural Adjustment Programme (ESAP) that was also being implemented at the time. This was compounded by ignorance and reluctance by some sections of society to acknowledge HIV/AIDS as a challenge (Ibid). The plans were subsequently replaced by the Zimbabwe National AIDS Policy of 1999.

3.2 Zimbabwe National Aids Policy Of 1999

It is a comprehensive national policy whose focus is not only on raising public awareness but also on the creation of a regulatory and operational framework for the purpose of fighting this pandemic through a sector-wide approach, involving the state and civil society (Government of Zimbabwe, 1999). The policy recognizes the need to address HIV/AIDS as a major priority for political support and promotes forms of social and resource mobilisation to mitigate the impacts of the pandemic (Baird 2006; Government of Zimbabwe, 1999; United Nations, 2009). The National AIDS Policy is being implemented through National AIDS Strategic Plans. The First Zimbabwe National AIDS Strategic Plan (ZANSP) of 2006 to 2010 was guided by the three ones principle (Zimbabwe AIDS Network, 2009b; 2010). These include one agreed HIV/AIDS action framework that provides the basis for coordinating of all partners, one national coordinating authority with a broad based multi-sector mandate and one agreed country level monitoring and evaluation system. It provided a foundation upon which guided coordinated effort by all sectors could be made.

To a large extent, the three ones principle created an organizational framework and conditions for the successful coordination and implementation of the national response to HIV and AIDS. It is however worth noting that it did not adequately address issues of community systems strengthening. It is against this backdrop that recognition of the role and contribution of community actors in the national response was targeted for strengthening (Ibid). The First has since been replaced by the Second Five-Year Zimbabwe National AIDS Strategic Plan running from 2011 to 2015. It is a result-focused and evidence-based intervention aimed at strengthening systems that contribute to HIV/AIDS and public health interventions at a community level (United Nations, 2009; Zimbabwe AIDS Network, 2009b; 2010). Implied in this is a shift towards welfare pluralism in-which the capacity of state and civil society organizations is being enhanced at all levels.

These combined efforts have resulted in a steady decline of HIV prevalence in the 2001 to 2009. HIV prevalence declined from 23, 7 percent in 2001 to 14, 3 percent in 2009 amongst adults aged 15 and above (United Nations, 2009; Zimbabwe AIDS Network, 2009a; 2010). A decline in HIV prevalence rate from 25, 78 percent in 2002 to 21, 3 percent in 2004, to 17 percent in 2006 and 16, 1 percent as of 2009 amongst pregnant women was recorded. Similar trends were also observed among younger pregnant women (15-24years) where prevalence declined from 20.8 percent in 2002, 17, 4 percent in 2004, and 12, 5 percent in 2006 to 11, 6 percent in 2009. The above downward trend in HIV prevalence among women aged 15-24 may be depicting a concomitant decline in HIV incidence in the population. The Zimbabwe Demography and Health Survey of 2005/06 further supported this decline by showing an HIV prevalence of 18, 1 percent in the general population in the 15-49 years age group.

The decline in HIV prevalence and incidence is attributed to initiatives by multiple actors which have resulted in changes in sexual behaviour specifically a decrease in number of sexual partners, increased condom use, increased knowledge about HIV/AIDS prevention and mortality (Ibid).

4.0 Methodology

Qualitative and quantitative methodologies were triangulated in this study. A survey was systematically carried out using structured questionnaires on 159 households in Ward 11 to quantify the impact of state and civil society HIV/AIDS policy interventions. Within each systematically selected household, individuals aged 12 years and above were systematically selected using the alphabetical order criteria of first names. This age group was selected on the basis that they were more mature enough to provide data which would facilitate the rating of interventions by health sectors in Mbare. Qualitative primary data was collected through key informant and in-depth interviews with key informants who include health service providers at all state and civil society institutions, community leaders and main recipients of their services in this community from amongst the affected and infected. Interview guides were used for this purpose. Secondary data was collected through a documentary search.

4.1 Study Area

The study was carried out in Mbare, a high-density suburb in the southern parts of Harare. It is a densely populated area, with a long history of settlement by both locals and migrants, having been the first high-density suburb to be established in 1907. It is also characterized by socio-economic activity which typifies Harare. It is because of its status that it was purposively selected for this study. Within this area, a survey that was carried out in Ward 11 which was randomly selected on the basis that HIV/AIDS affects all members and sections of the community in a manner that is similar and as such experiences were bound to be the same.

4.2 Target Population

Respondents were systematically selected using the alphabetical order criteria from households that were also systematically selected. Anyone 12 years and above, whose first name came first from a selected household qualified for the interview. Participation was voluntary and informed consent was sought from all participants whilst for those below 18 years, consent was sought from their parents or guardians.

4.3 Population Characteristics and Sample Size Determination

Total number of households in Mbare is 24 124.
Total number of households in Ward 11 is 7110 (Central Statistical Office, 2011).

4.4 Sample Size Determination Procedure

$$SS = \frac{Z * (p) * (1-q)}{e^2}$$

Where:
SS= Sample Size
Z = Z value (e.g. 1. 96 for 95% confidence level)
p = proportion of the target population to the entire population
e = confidence interval (0, 05)
q= proportion of the entire population excluding the target population

Therefore, a total of 159 individuals from 159 households were selected for the survey. It is worth noting that within this sample, the researcher came across 31 women who were in a position to answer questions relating to PMTCT. The researcher also came across 47 individuals who were in a position to answer questions relating to Treatment and Care as they were either affected or infected by HIV. Affected individuals included those whose household had an HIV infected individual under their care.

4.5 Data Presentation and Analysis

Qualitative data was presented in narrative form whilst quantitative data was presented in the form of tables. Data was analysed using tables in-which numerical findings were presented.

Analysis was based on responses on a scale of 5 ratings. In this a rating of 5 was considered excellent whilst 1 was poor. This provided a foundation upon which study conclusions were reached.

5.0 Presentation of Findings in Mbare

5.1 State and Civil Society Participation

5.1.1 Government Health Facilities

The study established that Mbare has five government health facilities which provide HIV/AIDS services listed in the table below.

Table 1: List of State Facilities in Mbare

Ward	Heath Centre Name	Status
3	Matapi	Clinic
11	Beatrice Road	Hospital
11	Mbare	Polyclinic
11	Medical Examination Centre	Clinic
12	Mbare Hostels	Clinic

The public health facilities listed in the table above include Matapi Clinic in Ward 3, Beatrice Road Hospital in Ward 11, Mbare Polyclinic in Ward 11, Medical Examination Centre in Ward 11 and Mbare Hostels in Ward 12. Amongst the services provided include Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), Epidemiology, Treatment and Care Programmes. The area is also serviced by the voluntary sector which includes aid organizations and formal churches.

5.1.2 The Voluntary Sector

Local and international Non Governmental Organizations (NGOs) are operative in Mbare District, providing HIV/AIDS programmes to the community. Amongst these include Population Services Zimbabwe (PSZ), Population Services International (PSI), Family Health International (FHI), Zimbabwe AIDS Network (ZAN) and Edith Opperman. It was established that NGOs are implementing their programmes in partnership with public health facilities. For instance, efforts has been made to scale up Family Planning/ Prevention of Mother to Child Transmission services to all facilities in the district. This follows training of in particular maternity health personnel and support initiatives from the Zimbabwe Partnership Project between Family Health International (FHI) and the Ministry of Health and Child Welfare which has resulted in the integration of Family Planning and HIV/AIDS. This is being complemented by Family Planning and Reproductive Health Programmes being implemented by PSZ. As a result of this, more pregnant women were attended to by a trained health worker at least once during pregnancy and HIV positive women attended to at health facilities where they received the More Efficacious Regimen (AZT/3TC and Nevirapine) to reduce chances of transmission of the virus from mother to baby. These efforts are being complemented by the Edith Opperman Maternity Unit at Mbare Polyclinic. It is facilitating the provision of PMTCT services to pregnant mothers and treatment to other members of the society. This indicates the efforts made by NGOs to work in partnership with state facilities to implement the National HIV/AIDS Treatment and Care Programme (OI/ART), part of the Plan for the Nationwide Provision of Anti-Retroviral Therapy 2008-2012. Challenges were however noted in this endeavour.

The study established that funding gaps have been a hindrance undermining the achievement of universal access to treatment and care in Mbare. Challenges which include a lack of essential equipment, high staff attrition, low morale of health professionals, dilapidated infrastructure and shortages of essential drugs are undermining efforts. For instance, the Edith Opperman Maternity Unit receives supplies from the International Committee of the Red Cross and the National Pharmaceutical Company of Zimbabwe (NatPharm), together with periodic support from the twinning arrangement with the City of Munich, Germany. However, these supplies have at times proved inadequate which has results delays in the screening for CD4 counts, which in turn results in delays in the provision of treatment. This situation is compounded by stock outs of HIV/AIDS drugs. The study also established the challenge of inadequate manpower for HIV patients in-which the facility had one nurse attending to 100 AIDS patients each day. These challenges undermine the extent to-which multi-sector collaborations may be considered effective in meeting the desired policy objectives.

NGOs are also working in partnership with state facilities to implement the National HIV/AIDS Treatment and Care Programme (OI/ART), part of the Plan for the Nationwide Provision of Anti-Retroviral Therapy 2008-2012.

Even though funding gaps have been a hindrance in terms of achieving universal access in the implementation of this programme, efforts to close in on them has been made by the government to subsides the local manufacture of Anti-Retroviral Drugs through the provision of foreign currency for the purchase of raw materials and waiver of import duty on raw materials for their production locally. A number of key players are also supporting the implementation of the policy and strategies espoused by the national pharmaceutical board, Nat-Pharm. In particular the United Nations Children's Fund, United States Government, Clinton Foundation, and the National AIDS Council are facilitating the procurement of these drugs. Once the drugs are procured and have arrived in the country, Nat-Pharm delegates the distribution of the drugs to the Ministry of Health and Child Welfare's AIDS and TB Logistics Sub-Unit which then distributes them to public health facilities in Mbare. Population Services Interantional (PSI) is also contributing towards the fight against HIV/AIDS through New Start and New Life Services provided through public health facilities in Mbare.

New Start Programmes are facilitating Voluntary Counselling and Testing (VCTs), whilst New Life Programmes are facilitating the provision of psychosocial support to the infected and affected members of the community. PSI also implements outreach programmes through which VCT services are provided through mobile facilities at shopping centres such as at Mbare Msika, Mai Musodzi Community Hall and Studdart Hall. However, inquiry established challenges in that these outreach facilities are not always available to all members of the community. Accessibility is undermined by urban livelihoods characterised by socio economic commitments in different sectors of the community. It was also established that the other reason for the lack of effectiveness of these facilities emanated from the geographical and population sizes of Mbare District which often mean that the facilities available are by far inadequate to meet the needs of each member of the community. HIV/AIDS education was however established to be effective as most locals are aware of the epidemiology around it. This may be attributed to the role played by the media in advocacy and information dissemination into different segments of the community.

Their efforts are being complemented by the Zimbabwe AIDS Network (ZAN). ZAN, created in 1992, is a network of organizations which consist of AIDS Service Organizations (ASOs), Community Based Organizations (CBOs), Faith Based Organizations (FBOs) and Private Sector organizations operational at a local community, district, provincial, national and international level in to facilitate effective response to HIV/AIDS. In Mbare, ZAN is working in partnership with Faith Based Organizations. Formal churches have had their fair share of contribution towards alleviating the HIV/AIDS pandemic. In Mbare district, the contribution has been two-pronged with the modern pentecostal churches immensely contributing towards behaviour change, proactive and reactive interventions. Mbare-based Pentecostal churches such as Zimbabwe Assemblies of God Africa (ZAOGA), Apostolic Faith Mission (AFM) and Family of God (FOG) have contributed towards HIV/AIDS prevention through educational programmes, meetings, and advisory committees for the young generation, youth, women, man, singles and couples.

The committees are responsible for teaching and moulding socially and biblically acceptable behaviour. Multiple partners are discouraged whilst the youth are discouraged from practicing sex before marriage. Single mothers are encouraged to fend for their children through entrepreneurship thereby discouraging them from dependency-induced multiple relationships. Couples are urged to be faithful to their partners. On a reactive level contributions are made towards child-headed families, orphaned and vulnerable children. However, unfavourable socio economic challenges have resulted in the contributions being inadequate to meet their needs meaning that most are forced into street vending or prostitution at tender ages. The informal sector is also playing a role in the fight against HIV/AIDS.

5.1.3 The Informal

In this sector, traditional churches have contributed less towards alleviating the pandemic as some of their values leave members at the risk of contracting the virus. Inquiry into the activities by the informal sector established that traditional churches and traditional healers also had a role to play in the fight against HIV/AIDS. The study established that traditional churches such as Johane Masowe Wechishanu, Johane Marange and Zvapupu zvaJehovha, which congregate at open spaces such as Mbare grounds, Pamapaipi and Magaba areas were also established to play an educational role.

However, whilst they discouraged anti-social practices such as sex outside marriage amongst their congregation, it was observed that reluctance by some, notably Johane Marange, to discourage polygamy and early intergenerational marriages amongst young girls were having a negative policy impact on joint efforts to combat HIV/AIDS as they often resulted in an expanded multiple concurrent sex network that promote its spread. It was established that this was compounded by spiritual beliefs which discourage the seeking of treatment in formal health facilities by members of the congregation. This often results in premature deaths as they cannot to access Antiretroviral Treatment. For their part, traditional healers were established to be playing a role of providing traditional herbs, medicine and spiritual guidance which is in line with the African culture. However, their guidance has militated against prevention as they are alleged to sometimes prescribe spiritual guidance which promotes the spread of HIV. For instance, some prescriptions which include appeasing the spirits through girl child compensation promote the spread of the pandemic, thus undermining policy efforts to fight the disease.

5.1.4 The Private Sector

Apart from the state and NGOs, private surgeries were also established to be playing a complementary role. It was established that Private Doctors were also providing HIV/AIDS services similar to those provided by government health facilities. The only difference is that they were providing such services at a comparatively higher fee which in most cases could only be met by the middle class who are on medical aid schemes. This means that their services were beyond the means of the majority. The study also established that the private business community is also playing a role by providing material resources for HIV/AIDS orphans and the elderly.

5.2 Analysis of the Study Sample

5.2.1 Ward 11

A survey was conducted to assess the impact of HIV/AIDS interventions being provided by state, voluntary, private and informal sectors on a sample of individuals drawn from households in Ward 11. The questions sought to determine through individual ratings, the impact of interventions which include Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), HIV/AIDS education, Treatment and Care Programmes. Respondents were asked to rate the services provided as illustrated in the tables below. May it be noted that note during survey, the researcher came across only 47 out of 159 people who responded yes to either being affected or infected by HIV/AIDS, and as such were in a position to answer the question on Treatment and Care. 31 of the 159 were responded yes to the question on PMTCT and were in a position to respond to the questions around that topic.

Table 2: Ratings on Government Health Facilities

Programme						
Rating value	**Excellent=5**	**Very Good=4**	**Good=3**	**Fair=2**	**Poor=1**	**Total average rating for each (Total of rating values/Total Responses)**
VCT	51	47	29	22	10	3,7
*PMTCT	13	9	7	2	0	2,1
HIV/AIDS Education/Information	61	39	44	13	2	3,9
*Care	2	11	9	14	11	2,6
*Treatment	5	10	6	11	15	2,6
Total Average Rating						**3**
Remarks						**Good**

As illustrated in the table above, Government Health Facilities received a total average rating of 3 from the responses made. This means that their interventions received a good rating in which HIV/AIDS Education and information received the highest rating of 3,9. The high rating was attributed to public information and educational interventions by health workers at Mbare Polyclinic, Medical Examination Centre and Beatrice Road Hospital in which 61 respondents viewed the interventions as excellent, 39 as being very good, 44 as good, 13 as being fair and 2 as poor.

It was established that the education and information was delivered through posters, pamphlets and, sometimes, public lectures by health personnel to members of the public who visit the facilities for medical consultation. VCT services by government health facilities received the second best rating of 3, 7. Part of this was attributed to the fact that these services are provided with support from partner NGOs which include Population Services International (PSI). 51 respondents viewed the service as excellent, 47 as very good, 29 as good, 22 being fair whilst 10 rated it as poor. Members of the community interviewed expressed appreciation of the fact that the VCT services provided a credible means of determining one's status. However, PMTCT services received the worst rating of 2, 1 from the women interviewed. Some of the respondents stated challenges which include drug shortages and the fact that there were no tangible mechanisms of making husbands accompany their pregnant wives when they go for regular check-ups. Given this, of the 31 respondents, 13 viewed it as excellent, 9 as very good, 7 as good, 2 as fair and none as being poor. An impact assessment was also carried out on interventions by the voluntary sector as illustrated in the table below.

Table 3: Ratings on the Voluntary Sector

Programme						
Rating value	**Excellent=5**	**Very Good=4**	**Good=3**	**Fair=2**	**Poor=1**	**Total average rating for each (Total of rating values/Total Responses)**
VCT	59	61	31	6	2	4, 1
*PMTCT	9	11	9	0	2	3, 8
HIV/AIDS Education/Information	61	52	34	8	4	3, 9
*Care	6	23	14	4	0	3, 7
*Treatment	9	18	13	5	2	3, 6
Total Average Rating						**3, 8**
Remarks						**Good**

Interventions by the voluntary sector, which is made up of NGO and formal churches also received a good rating of 3, 8 from the 159 responses. Of this, a highest total average rating of 4, 1 was achieved for VCT services, followed by HIV/AIDS Education and Information which received the second highest total average rating of 3, 9 and PMTCT which received a total average rating of 3, 8. Care interventions received the lowest total average rating of 3, 7 from which 6, of the 47 respondents either affected or infected by HIV/AIDS, viewed the interventions as excellent, 23 as being very good, 14 as good, four as fair and none as poor. The comparatively lower rating was attributed to delays in getting CD4 count at health facilities and drug shortages. An impact assessment on the private sector indicated an average total rating of 2, 5 as illustrated in the table below.

Table 4: Ratings on the Private Sector

Programme						
Rating value	**Excellent=5**	**Very Good=4**	**Good=3**	**Fair=2**	**Poor=1**	**Total average rating for each (Total of rating values/Total Responses)**
VCT	17	14	49	36	43	2,5
*PMTCT	11	9	8	2	1	3,9
HIV/AIDS Education/Information	13	19	14	102	11	2,5
*Care	1	5	6	9	26	1,9
*Treatment	2	3	2	7	33	1,6
Total Average Rating						**2,5**
Remarks						**Fair**

This indicated a fair rating on interventions by the private sector which includes private surgeries and local businesses which support the fight against HIV/AIDS. PMTCT services by private surgeries received the highest rating of 3, 9 in this category. Their services were viewed as high class by the majority of the respondents whilst others stated that private surgeries were better equipped and comparatively less congested. As such, of the 31 respondents, 11 viewed the PMTCT services as excellent, 9 as very good, 8 as just good, 2 as being fair whilst 1 as being poor. However, treatment received a lowest rating of 1, 6 in-which 2 of the 47 respondents viewed it as excellent, 3 as being very good, 2 as being good, 7 as being fair and 33 for being poor. This was due to the fact that most respondents viewed it as comparatively more expensive to seek treatment through private surgeries as they either required cash or that one be on a medical aids scheme, a facility which is only available to the few working class in the formal sector. Related to this was a total average rating of 1, 6 made on the informal sector as illustrated in the table below.

Table 5: Ratings on the Informal Sector

Programme						
Rating value	**Excellent=5**	**Very Good=4**	**Good=3**	**Fair=2**	**Poor=1**	**Total average rating for each (Total of rating values/Total Responses)**
VCT	3	2	0	8	146	1, 2
*PMTCT	0	1	3	15	12	1, 5
HIV/AIDS Education/Information	50	38	25	17	29	2, 8
*Care	1	2	1	11	32	1, 5
*Treatment	0	1	1	6	39	1, 2
Total Average Rating						**1,6**
Remarks						**Poor**

Within this poor total average rating, HIV/AIDS Education and Information had the highest rating of 2, 8. This was attributed to the educational role by traditional churches and traditional healers who discourage promiscuity and other anti social behaviour such as prostitution. 50 of the 149 respondents viewed this role as excellent, 38 as being very good, 25 as good and 17 as fair. However, 29 respondents viewed this role as being poor citing the fact that these informal institutions are not reaching out to all members of the community in a coordinated manner and that in almost all cases, their education was through teachings not supported by documentation with some facts and statistics about the epidemiology around HIV/AIDS. The failure to reach out to all members of the society was also attributed to issues of affiliation in which these institution were failing to reach out to all members of the public because were reluctant to join whilst viewing them as not being in line with their own beliefs.

In a nutshell, the state, and civil society are playing a role in confronting the challenges associated with HIV/AIDS. The Voluntary Sector received a good and highest rating of 3, 8 from respondents. This was followed by another good rating of 3 for government institutions and a fair rating of 2, 5 for the private sector. The informal sector received a poor rating of 1, 6 which made it the lowest rated of actors operational in Mbare. Nevertheless, the good and fair ratings for the state, voluntary and private sector indicate combined effort in the community whilst the poor rating for the informal sector indicates gaps that still have to be exploited to maximise the gains from efforts.

6.0 Conclusions

It was concluded that since the discovery of HIV/AIDS in 1985, the government of Zimbabwe has committed itself to Welfare Pluralism in responding to the pandemic. In this, a sector-wide approach was adopted to facilitate the implementation policy interventions which include the National AIDS Coordinating Programme of 1987 which adopted the World Health Organization model of Medium-Term Plans. This was implemented through the One Year Emergency Short-Term Plan of 1987-88, the First Medium-Term Plan of 1988-93, and the Second Medium-Term Plan of 1994-98. These culminated into the Zimbabwe National AIDS Policy of 1999, which is being implemented through the Zimbabwe National AIDS Strategic Plans.

The study concluded that in Mbare, these policies were being implemented through public health facilities, NGOs, formal churches, private health institutions, private businesses and the informal sector. Public health facilities which include Matapi Clinic in Ward 3, Beatrice Road Hospital in Ward 11, Mbare Polyclinic in Ward 11, Medical Examination Centre in Ward 11 and Mbare Hostels in Ward 12 were providing services which include Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), Epidemiology, Treatment and Care Programmes. The area is also serviced by the voluntary sector which includes aid organizations and formal churches. These include local and international Non Governmental Organizations (NGOs) which are implementing HIV/AIDS programmes to the community. Amongst these include Population Services Zimbabwe (PSZ), Population Services International (PSI), Family Health International (FHI), Zimbabwe AIDS Network (ZAN) and Edith Opperman. It was established that NGOs are implementing their programmes in partnership with public health facilities. For instance, efforts have been made to scale up Family Planning/ Prevention of Mother to Child Transmission services to all facilities in the district.

This follows training of in particular maternity health personnel and support initiatives from the Zimbabwe Partnership Project between Family Health International (FHI) and the Ministry of Health and Child Welfare which has resulted in the integration of Family Planning and HIV/AIDS. It was also concluded that these efforts are being complemented by the Edith Opperman Maternity Unit at Mbare Polyclinic. It is facilitating the provision of PMTCT services to pregnant mothers and treatment to other members of the society. This indicates the efforts made by NGOs to work in partnership with state facilities to implement the National HIV/AIDS Treatment and Care Programme (OI/ART), part of the Plan for the Nationwide Provision of Anti-Retroviral Therapy 2008-2012. Challenges were however noted in this endeavour.

The study established that funding gaps have been a hindrance undermining the achievement of universal access to treatment and care in Mbare. Challenges which include a lack of essential equipment, high staff attrition, low morale of health professionals, dilapidated infrastructure and shortages of essential drugs are undermining efforts by the Edith Opperman Maternity Unit. The study also concluded that there was a challenge of inadequate manpower for HIV patients in-which the facility had one nurse attending to 100 AIDS patients each day. These challenges undermine the extent to-which multi-sector collaborations may be considered effective in meeting the desired policy objectives. Other NGOs are also working in partnership with state facilities to implement the National HIV/AIDS Treatment and Care Programme (OI/ART), part of the Plan for the Nationwide Provision of Anti-Retroviral Therapy 2008-2012. Population Services Interantional (PSI) is also contributing towards the fight against HIV/AIDS through New Start and New Life Services provided through public health facilities in Mbare. Their efforts are being complemented by the Zimbabwe AIDS Network (ZAN) which is working in partnership with Faith Based Organizations.

The study also concluded that the informal sector had a role to play in the fight against HIV/AIDS. It was however concluded that some practices such as polygamy within some of the traditional churches actually contribute to the spread of HIV. Some practices by traditional healers also added to this situation as it militated against prevention of the spread. The study also concuded that private doctors were also providing HIV/AIDS services similar to those provided by the government health facilities. The only difference is that they were providing such services at a comparatively higher fee which in most cases could only be met by the middle class who are on medical aid schemes. This means that their services were beyond the means of the majority. The study also established that the private business community is also playing a role by providing material resources for HIV/AIDS orphans and the elderly. A survey was conducted on respondents from 149 households in Ward 11. This led to the conclusion that the state and civil society are playing a role in confronting the challenges associated with HIV/AIDS.

The Voluntary Sector received a good and highest rating of 3, 8 from respondents. This was followed by another good rating of 3 for government institutions and a fair rating of 2, 5 for the private sector. The informal sector received a poor rating of 1, 6 which made it the lowest rated of actors operational in Mbare. Nevertheless, the good and fair ratings for the state, voluntary and private sector indicate combined effort in the community whilst the poor rating for the informal sector indicates gaps that still have to be exploited to maximise the gains from efforts. The study concluded in all that combined effort which is complementary by all sectors will go a long way towards totally eliminating this emergent global threat to mankind.

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